

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name:</b> Viernes, May G. (ARCH)	<b>CHAPTER 100.1</b>
<b>Address:</b> 94-1184 Hina Street, Waipahu, Hawaii 96797	<b>Inspection Date:</b> November 12, 2019 Annual

**THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.**

**YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition.</u> (i) Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit.</p> <p><b><u>FINDINGS</u></b> Resident #1 – Please clarify diet.</p> <ul style="list-style-type: none"> <li>• 2/21/19 Annual Physician's Evaluation states Regular Diet</li> <li>• 5/23/19 Signed Office Visit Note states "Limit saturated fats in your diet. Reduce intake of trans fat lowers LDL cholesterol and increases HDL cholesterol. Avoid concentrated sweets, white starches such as sugar, potatoes, things made with flour and white rice."</li> </ul> <p>Please fax clarification with plan of correction.</p>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>Yes. I went to see physician to clarify diet and signed on this day, 11/18/19</p>	<p>11/18/19</p>



Licensee's/Administrator's Signature: mg Verner

Print Name: MAY G. VERNES

Date: 11-20-2019

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